The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage contact the division at 1-800-821-2251. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.AlaskaCare.gov or call 1-800-821-2251 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/individual or $600/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services with an in-network provider, some primary care services, and some specialty care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. For example, this plan covers certain in-network preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.alaskacare.gov
Are there other deductibles for specific services?	No.	There are no separate deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $1,750 individual / $3,500 family; for out-of-network facilities $3,500 individual / $7,000 family; prescription drug coverage: individual $1,000 / family $2,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for non-emergency care at an emergency room of a hospital and health care services this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See AlaskaCare.gov or call (855) 784-8646 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. **Copayments** do not apply to your **deductible**, but do apply to your **out-of-pocket limit.**

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit, deductible does not apply to office visits	20% coinsurance employee only; 70% dependents	Facility charges, ancillary services and other services not billed as part of an office visit by the primary care physician will be subject to deductible and coinsurance. 20% coinsurance for hearing benefits. $0 copay (preventive care); $25 copay (non-preventive care)/Coalition Health Clinic (including associated lab work). $0 copay for Teladoc general medical consultation.
	Specialist visit	$45 copay per visit, deductible does not apply to office visits	20% coinsurance employee only; 70% dependents	Facility charges, ancillary services and other services not billed as part of an office visit by the specialist will be subject to deductible and coinsurance. Chiropractic care coverage is limited to 20 visits per calendar year. $0 copay for Teladoc dermatology consultation.
	Preventive care/screening/ immunization	No charge	20% coinsurance employee only; 70% dependents	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance employee only; 70% dependents	40% coinsurance facility services employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside of Alaska. Precertification is required for some imaging services when using an out-of-network provider.
	Imaging (CT/PET scans, MRIs)	20% coinsurance employee only; 70% dependents	40% coinsurance facility services employee only; 70% dependents	
If you need drugs to treat your illness or condition	Maintenance generic prescription drugs	$5 maximum copay per prescription up to a 30-day supply; $10 copay per prescription via home delivery (31-90-day supply).	40% coinsurance	Covers up to a 30-day supply (retail). Home Delivery can be used for a 90-day supply of any qualified prescription drug.
	Generic drugs	$10 maximum copay per prescription up to a 30-day supply; $20 copay per prescription	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at www.AlaskaCare.gov		via home delivery (31-90-day supply).		Covers up to a 30-day supply (retail). Home Delivery can be used for a 90-day supply of any qualified prescription drug. If you are prescribed an eligible specialty drug, you may enroll in OptumRx's Variable Copay Solution (VCS) program to reduce your copayment for that drug.
	Preferred brand drugs	$35 maximum copay per prescription up to a 30-day supply; $50 copay per prescription via home delivery (31-90-day supply).	40% coinsurance	
	Non-preferred brand drugs	35% coinsurance with $80 min / $150 max per prescription up to a 30-day supply; $100 copay per prescription via home delivery (31-90-day supply).	40% coinsurance	
	Specialty drugs	see preferred/non-preferred brand name drugs.	40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance employee only; 70% dependents	40% coinsurance facility services employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Precertification is required for some services when using an out-of-network provider. No cost after you meet your deductible for episode of care received through SurgeryPlus.
	Physician/surgeon fees	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	
If you need immediate medical attention	Emergency room care	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	20% coinsurance after $100 penalty per visit for non-emergency use.
	Emergency medical transportation	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	None
	Urgent care	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance employee only; 70% dependents	40% coinsurance facility services employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Precertification required for out-of-network care. No cost after you meet your deductible for episode of care received through SurgeryPlus.
	Physician/surgeon fees	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 copay	20% coinsurance employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Precertification required for out-of-network care. Teladoc Behavioral Health consultation $0 copay.
	Inpatient services	20% coinsurance employee only; 70% dependents	40% coinsurance facility services employee only; 70% dependents	
If you are pregnant	Office visits	No charge	20% coinsurance employee only; 70% dependents	None
	Childbirth/delivery professional services	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Precertification required for out-of-network care. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance employee only; 70% dependents	40% coinsurance facility services employee only; 70% dependents	
If you need help recovering or have other special health needs	Home health care	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	Coverage is limited to 120 visits per calendar year. Precertification required for out-of-network care.
	Rehabilitation services	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	Coverage is limited to 20 visits per benefit year for spinal manipulations.
	Habilitation services	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Precertification required for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		employee only; 70% dependents	employee only; 70% dependents	
	Durable medical equipment	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	None
	Hospice services	20% coinsurance employee only; 70% dependents	20% coinsurance employee only; 70% dependents	Precertification required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental exam	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Dental care (Adult and Child) except as related to medical conditions of the teeth, jaw, and jaw joints as well as supporting tissues including bones, muscles, and nerves.
- Infertility treatment
- Long-term care
- Routine eye care (Adult and Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Bariatric surgery (one morbid obesity surgical procedure within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.)
- Chiropractic care (20 visit limit per benefit year)
- Cosmetic surgery (Only to improve a significant functional impairment of a body part; to correct the result of an accidental injury; to correct the result of an injury that occurred during a covered surgical procedure within 24 months after the original injury; to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when the defect results in severe facial disfigurement, or the defect results in significant functional impairment and the surgery is needed to improve function.)
- Hearing Exam (once every 24 rolling months), 20% coinsurance
- Hearing Aids (maximum $3,000 payable every 36 rolling months), 20% coinsurance
- Medical treatment of obesity including physical exam and diagnostic tests, outpatient prescription drugs and one morbid obesity surgical procedure
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (provided by R.N. or L.P.N. if medical condition requires skilled nursing services and visiting nursing care is inadequate)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at (855) 784-8646. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide

complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the claims administrator at (855) 784-8646, the plan administrator at (800) 821-2251, or:

Aetna
Attn: National Account CRT
P.O. Box 14079
Lexington, KY 40512-4079

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al (855) 784-8646.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (855) 784-8646.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 784-8646.

中文): 如果需要中文的帮助，请拨打这个号码 (855) 784-8646.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$
Coinsurance	$1,500
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,810**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$300**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$900
Coinsurance	$400
What is not covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$300**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$100
Coinsurance	$1,300
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

The plan would be responsible for the other costs of these EXAMPLE covered services.